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The Importance of Being Perverse: Troubling Law, Identities, Health and Rights in Search of Global Justice

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1 Why Should Sexual Health Policy Makers and Practitioners Be Concerned with Contemporary Struggles in Human Rights?

The premise of this chapter is that policy makers and practitioners concerned with sexual health or with the health of persons of diverse sexualities can and should be part of a global struggle for justice and rights. At the same time, because rights claims for gay-identified or sexually and gender-nonconforming persons do not automatically encompass broader justice claims in health, we seek to explore the tools and principles in health, rights, law, and sexuality that open or close down a connection to broader justice. We suggest that the process of theorizing and practicing an integrated approach to sexuality—critiquing and linking the worlds of health, law, and human rights—can result in practices and positions that are more than mere sums of our current understanding and thus contribute to politically strategic and self-conscious strategies of coalition with others seeking greater justice in health.

We argue this because of a belief that health and law are in themselves sites of practice and experiences of social justice—or injustice—at local and global levels. Health systems and all the players and forces in them can be analyzed for their impact on human dignity, equality, and freedom as well as for their effectiveness in preventing or treating ill-health or disease. Linking health with human rights has become a key for many variously empowered people demanding change in the structures that provide health services and care globally (Freedman, 1995b; Farmer, 1999; Yamin, 2002). More than that, however, linking health systems with justice claims requires health policy makers to assess the power structures within which they operate and use even as they "do good" by organizing or delivering health care (Mackintosh, 2001; Gilson, 2003).

Law plays a significant role with respect to health as well as to sexuality. The discourse around law, health, and sexuality is not simple, however, as there is rarely a direct relationship among the three, although they intersect in ways that produce multiple meanings. The rights and law discourse, for example, includes the notion of identities, behavior, and expression; individuals and groups; claims of actors and responses of states (and supranational organisms). Law is then functionally linked as a tool for respecting, protecting, and fulfilling rights. As for the field of health, the questions of (human) rights and (social) justice vis-à-vis health requires a discussion of principles, policies, and practices. The emergence of sexual rights as an overarching category of rights claiming—encompassing lesbian/gay/bisexual/transgender (LGBT) claims, sexual and reproductive health, responses to sexual harm and other linked claims—demands similar, careful analysis, especially regarding its connection to law.

Moreover, rights work and law-as-rights practice demand an understanding of how gender, race, and sexual power structures are linked—connections that are revealed in national discourses of anxiety arising in South and North. Sexual rights claims have generated some affirmative responses in international, regional, and national law and standards. However, progress has been uneven and inconsistent, such as between same-sex and different-sex sexual rights, across genders, among ages, and between nations and global regimes. There have been varied deployments of the rights claims based on identity, personhood, equality, privacy, freedom, autonomy, health, and dignity (Fried & Landsberg-Lewis, 2000; Miller, 2000; Katyal, 2004; Saiz, 2004), with limited success vis-à-vis the rights recognition of diversity of gender expression. We argue in this chapter that an aspect of that incoherence in sexual rights—especially its exclusionary tendencies—is linked to the qualities of law as a system of categorization, in this case through binaries and rigid group line drawing.

Thus, for persons interested in how rights-oriented work in health can serve the health, dignity, and respect for sexually diverse persons, understanding the current status and context of sexual rights claiming as well as its inner fault lines and biases, especially as linked to the domains of law and health is critical. Although the conversation about sexuality and rights, health, and law is global, the nature and impact of the specific local/international interaction varies: There is no "global gay" with the power to compel identity formation, but there are hegemonic terms, variable portals of entry, and mechanisms of inclusion and exclusion linked to health and law (media, markets, travel/migration, and advocacy campaigns to name a few) interacting with widely divergent local interests and stratifications across gender, race, class, age, religious, rural/urban, and linguistic exchanges—sets of variables that help determine the shape of claims, practices, and identities.

1.1 Using or Avoiding Convenient and Politically Adept Shorthand for Sexual and Gender Claims?

We sometimes use several less common terms here to speak of the galaxy of *nonnormative sexualities* and *gender roles*, rather than the widely used

acronym LGBT or the convenient shorthand "sexual minorities." We are aware our longer phrases may be disorienting, but as the primary thrust of our inquiry challenges the way law, rights, and health have arrived at fixed categories of sexuality, we cannot make use of the very definitions we are problematizing. During various political struggles, locally and globally, the terms have functioned as dual-edged swords, often progressively cutting through thickets of opposition to the rights claims of sexually marginalized persons and at times cutting out others from the benefits of the rights claims (Rubin, 1984).

Thus, we do not use terms such as "sexual minorities," which often appears to be good shorthand, laying claim to an existing, apparently analogous system of antidiscrimination. Yet "sexual minorities" does not delimit a meaningful group—By what set of criteria are members of this minority defined? Is it identity-based or practice based? When do we deem sexual identities sufficiently coherent and practices sufficiently nonmajoritarian? Women who have sex outside marriage are deemed a member of a sexual minority if they are same-sex loving but not a member of a sexual minority if they have sex with men outside marriage, with or without pay, even though globally such women are stigmatized and legally and nonlegally attacked. Is a sexual minority permanent/rigid/embodied? Cultural/temporary/flexible? Life and harm is most often experienced as intersectional; and people (both as individuals and groups) fit many and diverse categories shaped across differently functioning axes of gender, sexuality, race, age, health, and religion. If a sociolegal system does not respond to the barriers and inequalities experienced together (intersectional) or separately, as Crenshaw shows, it perpetuates the mechanisms of subordination instead of producing social justice (Crenshaw, 1991). Thus we are left with ungainly phrases: nonheteronormative sexual behavior; locally self-identified gay and lesbian, among others.

1.2 Why Investigate Health and Sexual Rights So Skeptically?

During the last decade, one of the greatest areas of progress for sexual rights has been in health—the right to health specifically but also in regard to the various health effects of sexual acts: the human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) pandemic and responses to sexual violence against women being among the most generative of these conversations (Miller, 2001). The focus on sexual health as a strategy to develop and claim "sexual rights" has been important: nonetheless, although it appears politically tempting to claim more aspects of sexual rights through this approach (as it sidesteps certain condemnations based on religion, culture, or morals), we should be wary of over-medicalizing a constellation of social and biologic processes that encompass domains of imagination, expression, and communication, law, religion, and economics as well as the body (Vance, 1999; Miller, 2000). Health cannot be presumed to be a benign site for sexuality, especially homosexuality. Through knowing the history of medical and psychological interventions that oppress lesbians, gay men, and bisexual persons, including the very naming of "homosexuality" as a disease, and the complicated relation

between transsexuality and medical intervention, progressive strategies for better care and services for persons of disparate sexualities face the reality that medicine can also function as a regime of control, alone or in partnership with law including criminal laws and public health legislation (Miller, 2001). This reality links to our interrogation of law and rules. How diverse sexualities face inclusion, regulation, and/or exclusion in health bolsters our concern with health systems as a site of social transformation or continued exclusion and therefore becomes a topic of broader global justice.

Concepts of "sexual health" and "healthy sexuality" have dangerous tendencies to slide from denoting sexual behaviors carried out without coercion, violence, or exposure to disease to connoting "normal, naturalized" sex, creating a hierarchy that excludes diverse—or to some, perverse—sexualities (Miller, 2001; Miller & Vance, 2004). Moreover, this slide alerts us to the many valences of sexual judgment in health, and that talking about sexuality within the context of health should not imply that all of the demands of sexuality are encompassed in the domain of health. Conversely, one's sexuality is not the only aspect of identity or behavior affecting health status; a "sexual health and rights" approach should constantly explore and relink the focus on sexuality and health to the many social determinants (e.g., occupational environment, job and social security, poverty, housing, education) factored across other key variables, such as race and sex, that affect health status. Although access to health care does not equal good health, good health nonetheless requires available, accessible, acceptable, quality health services.

The picture for sexual rights is further complicated by the fact that the sociolegal paradigm of identity should not be tethered only to sexual behavior, however much the health lens tends toward that bias. Other elements play important roles: Expression encompasses political, cultural, or personal expression and physical (nonsexual) expression. Expression is also relational, functioning in regard to seeing and being seen by another in both intimate and social contexts. Expression, behavior, and the social and political linkage of these factors to an identity can generate both solidarity and discriminatory conduct or policies. Under these circumstances and in the context of health, we are always asking, then, for what reason do we want to identify a person: to better protect a category of persons or to understand their probable sexual behaviors? These can be related or noncontiguous concerns. Thus, the law's language needs to be shaped in ways that elucidate rather than obscure the understanding necessary to reach these goals.

1.3 Themes and a Road Map

We thus perversely unsettle language and overly neat claims about health, rights, law, and sexuality as part of a project to use these same concepts to increase both the well-being of specific marginalized persons and overall global well-being and justice. In the sections that follow, we enumerate some of the specific principles that underlie rights claims,

map the current status of (predominantly homo) sexual rights claiming and geopolitics, and finally set out the geopolitical context of sexual rights claiming. We pay particular attention to the operation of health systems on the one side and law on the other as we argue for rights-based approaches to sexual and gender diversity in health settings.

At the same time, our concern with the impact of the connected but distinct systems of principles and rules (or rights and regulation) suggests the multiple domains where we must look to view these connections between health, sexuality, and rights. The application of principles in health and rights sometimes produces rules on sexual rights, such as through national or international judicial processes, and can be found in diverse branches of law (e.g., criminal, family, citizenship/immigration, labor/employment); it sometimes produces policies that affect sexual health, which must be sought in health law/administration of public health or the practice of health institutions. The forms and effects of such policies and regulations are multiple and massive: As Meyer (2001) points out, due concern by persons in public health with just LGBT sexuality (leaving aside other forms of marginalized sexual behavior or heteronormative sexuality) encompass attention to increased risk for diseases directly or indirectly linked to sexual practices, specific health care issues for transgender people, and attention to mental health, adolescent development, and violence to name a few.

In the exploration that follows, we present four interlinked inquiries. We make these inquiries with reference to the status of various sexual rights claims in the formal world of international human rights, noting particular junctures and disjunctures occasioned by the evolution of health and human rights as a growing part of the human rights movement generally. First, we are concerned with how sexuality and rights claims arise in health claims and how they function in the current political context. This global discourse contains multiple sites of contestation and surges, exclusions, and retrenchments in sexual rights work, often in the context of struggles over national sovereignty and economic power. Second, we are concerned with the operation of law vis-à-vis gender and sexuality because law is a site of power itself and is deeply implicated in these struggles, often in the guise of legal entitlements to health services. Our arguments flow from the insight that the law contributes to the creation of personages so it can attribute rights and duties to them (Lorber, 1994). Thus, we explore how, even as law comes to accept that persons can change gender, it still requires the selection of one of two genders, predicated on a biologic regime in which one can find male and female bodies.

Finally, we connect concerns for law, rights, and sexuality with an inquiry into health as a site of justice. We believe that the health systems into which sexually marginalized individuals and groups demand inclusion are often unevenly accessible because of race, gender, ethnicity, migrancy, poverty, or geographic/rural status as well as uneven distribution of resources nationally and globally (Freedman et al., 2005). Thus, if health systems are a core piece of global health, rights, and justice work today, how do health practitioners working with diverse sexualities, genders, and practices fit into this movement?

Because law as a tool of rights often plays a central gate-keeping role, our chapter seeks to explore contradictory aspects of the law that may simultaneously protect rights and undercut them. We explore the ways in which some legal successes, modeled on culturally limited terms of identity, are either exclusionary or simply insufficient. In particular, we look at specific sites, one trans-European and the other India-specific, regarding transsexuality and criminal regulation of (same sex) sexual practice, respectively, as two key issue areas that have entered many health policy debates to create new categories of people—trans-gendered persons and homosexuals.

We turn first to the connections between health and rights, and the places that sexual rights claims have arisen in health. We also highlight key principles that underlie rights-based approaches, such as account-ability, nondiscrimination, and participation. We then explore the congeries of legal rights as well as some critical fault lines through both theoretical and grounded inquiry in case studies: on the global, geopolitical engines and architecture of sexual rights claims, and on regional (Europe) and national (India) examples of sexual- and gender-linked rights claims. We close our case studies with a return to health as a site of potential justice and injustice in regard to the forces affecting health systems, in which health policy makers and practi-tioners work. Our conclusion notes the paradoxes of an unstable and contested rights system as the source of local work but argues that this is the best way forward to ensure that the local effects contribute to a greater system of justice and equity in health and in the society as a whole.

Our goal throughout, however, is to build the case for arguing that neither *human rights*, its sometimes handmaiden/sometimes tyrant law, nor *health*, so beneficently appearing, should be employed without examining the ways in which each concept functions to divide, rank, or make invisible the very diversity of persons and their sexual-ity that we seek to enable and celebrate when we use human rights claims.

2 Health and Human Rights Engage: What Is the Global Context? What Are the Principles? With What Effects on Sexual Rights?

2.1 Health and Human Rights: Tools of Accountability

Although "health and human rights are both powerful, modern approaches to defining and advancing human well being," the field of their intersection still grows slowly (Mann et al., 1999). Recent global work to develop the concepts of health and human rights includes at least four approaches to their connection: the health effects of human rights violations, the human rights effect of health policies, the syner-gistic connections between rights promotion and health promotion, and the claim to the right to health itself.

Table 1. Selected United Nations Human Rights Treaties and Their Monitoring Committees

CEDAW: Convention on the Elimination of all Forms of Discrimination against Women (adopted by U.N. General Assembly in 1979)
CEDAW: Committee on the Elimination of Discrimination against Women
CRC: Convention on the Rights of the Child (adopted by U.N. General Assembly in 1989)
CRC: Convention on the Rights of the Child
ICCPR: International Covenant on Civil and Political Rights (adopted by U.N. General Assembly in 1966)
HRC: Human Rights Committee
ICERD: International Convention on the Elimination of Racial Discrimination (adopted by U.N. General Assembly in 1965)
CERD: Convention on the Elimination of Racial Discrimination
ICESCR: International Covenant on Economic Social and Cultural Rights (adopted by U.N. General Assembly in 1966)
CESCR: Committee on Economic Social and Cultural Rights
UDHR: Universal Declaration of Human Rights (adopted by U.N. General Assembly in 1948)

When exploring human rights, we not only call on the international system of rights-standard setting and monitoring (the United Nations) but also look to and draw from regional and national experiences. In the discussion that follows, we use the standards, reports, and determinations of a range of actors created through the United Nations' human rights system. There are rights systems at local, national, and regional levels as well, but here we concentrate on the international standards created by national governments (often through tools called treaties and conventions) that are debated publicly international and are of global reach. (See the list of major human rights treaties and committees and their commonly used abbreviations in Table 1.)

Diverse forms of engagement between rights and health evolved in part because of different doctrinal, political, and methodologic foci in human rights as it looked to health. For example, during the Cold War the prioritization of such civil and political rights as freedom from torture in the West led to a link to health through the need for health responses to torture (the health effects of human rights' violations); the end of the Cold War dissipated this privileging, opening up the discussion to the broader obligations of the right to health. Later, in Section 3, we speak to the challenges currently facing human rights claims, especially sexual rights, in part through the specific actions of the United States, and other actors globally. Before we deal with the politics of rights, including sexual rights, though, we explore the doctrinal claim of rights and its relation to the modern state.

The political assumptions of the doctrine must be held in mind. Human rights as a system is doctrinally predicated on a vision of

the modern state that is, at face value, a neo-Keynesian welfare state (Sen, 2005). Politically, this state model is under attack in the current globalizing world. Critics of rights proponents' too-easy remit with status quo geopolitical state arrangements have argued that this vision of the modern state was always partial, biased, and hiding a set of interests that perpetuated regimes of control and empire (An-Na'im, 2004). We return to this critique at our conclusion, but here we engage with the doctrine on its own terms.

The foundational claim of rights is that states are legally accountable for the well-being of all the people under their jurisdiction and control. Moreover, to evaluate state accountability for rights, including health, the doctrine has evolved to use a tripartite structure that sets out the scope and nature of this accountability, using the language of *respect*, *protect*, and *fulfill.*

Governments are required to *respect* rights (the state and its agents must not through their own actions violate rights). This principle was demonstrated when an independent expert for the U.N. Commission on Human Rights, the Special Rapporteur against Torture, in 2001 reported that persons in detention were beaten or otherwise abused because of their sexual orientation or gender identity (Special Rapporteur of the Commission on Human Rights, 2001) or when in 2002 both the Committee on Economic Social and Cultural Rights (CESCR), which monitors the Covenant by the same name, and the Committee on the Elimination of Discrimination Against Women (CEDAW), which monitors the Convention of that name, criticized Kyrgyzstan for its criminalization of lesbianism as a form of violence against women (Committee on the Elimination of all forms of Discrimination against Women, 1999; Committee on Economic Social and Cultural Rights, 2000).

States are required to *protect* rights (the state must organize all branches to ensure that no other entity—private person, corporation—abuses human rights with impunity), as when the Human Rights Committee, which monitors the International Covenant on Civil and Political Rights (ICCPR), criticized the United States in 1994 not only for its then same-sex sodomy laws but also because such laws gave rise to stigma leading to discrimination and violence against persons by other private actors (Human Rights Committee, 1994). This principle is also at work when the European Court of Human Rights (a regional court, see later) found Bulgaria in violation of its obligations to protect, through failure by local police officers' investigating a rape by private persons, because their actions failed to meet the standard of due diligence—a standard of review for the obligation to investigate, prosecute, remedy, or prevent violations of rights, in this case rights that redound to promoting sexual and bodily integrity and decision-making (X, Y, and Z v. the United Kingdom, 1997).

Finally, the state must *fulfill* rights (sometimes called *promote*), meaning that the state must also ensure that its actions, at all levels, through administrative, legislative, judicial, fiscal, budgetary, or other means, make the enjoyment of rights possible. In the case of (sexual) health, this obligation could be met by taking steps to ensure that nondiscriminatory and effective mechanisms are in place to respond to

epidemic diseases such as HIV/AIDS or by facilitating the infrastructure for an open and diverse society by ensuring, inter alia, that gay and lesbian advocacy groups can carry out health advocacy without legal strictures or fear of violence, as noted by the Special Rapporteurs on the Rights to Health and Human Rights Defenders (Special Rapporteur on the Right to Health, 2004).

This tripartite ordering of obligations applies to all rights and puts an end to the false dichotomization of rights between affirmative and negative, although it leaves open the actual content of each intervention. It thus puts the gender, race, and sexual ideology of the state front and center in regard to sexual rights. For example, the Committee on the Rights of the Child (overseeing the Convention on the Rights of the Child) interprets the right to information as a right for adolescents to have access to the sexual health information necessary for them to protect their health and lives, regardless of their sexual orientation—information the state must either provide or facilitate easy access to (Committee on the Rights of the Child, 2003a,b). One could imagine both wanting the state not to censor information provided by diverse sexual advocacy groups as well as needing to ensure that the information affirmatively provide by the state is free of gender and sexual stereotypes. A review of the Indian state-supported "life education" course "Learning for Life" for students in grades 9 to 11 reveals that the state-mandated education is replete with gender stereotypes for (modest) heterosexual girls and (sexually adventurous) heterosexual boys (Badrinath, 2005). As Freedman (1995a) cautioned, "the very notion of an IEC (information, education, and communication) strategy designed by government officials for the explicit purpose of changing the [sexual and reproductive] behavior and attitudes of a selected group of people, should give human rights advocates pause."

As the post-Cold War rhetoric that "all rights are universal, interdependent, and interrelated" becomes more accepted, the fact that individual nations/states are not sufficient to guarantee rights has garnered more attention. Health increasingly figures in the human rights discourse (and a competing/overlapping global public goods discourse) as an example of a right that is not within the control of any one state (Smith et al., 2003; Barrett, 2004). In the original 1940s framework for rights, there is good evidence that states were not meant to be solely responsible for the all the conditions necessary for rights, viz. the Universal Declaration of Human Rights, article 28: "Everyone is entitled to a social and international order in which the rights and freedoms set forth in this Declaration can be fully realized" (Universal Declaration of Human Rights, 1948).

Later human rights treaties are increasingly interpreted to explain the importance of state contributions to international enabling conditions and the ways that reporting states' actions affect the enjoyment of rights in entirely separate nations (Limburg Principles, 1987; Maastricht Guidelines, 1998). The Committee that monitors the CESCR has begun a practice of quizzing states' reports, based on the idea that states have accountability for the extranational health effects of their policies (Limburg Principles, 1987; Maastricht Guidelines, 1998; Yamin,

2002) The Special Rapporteur on the Right to Health has said that nations can be evaluated on the health effects of the policies they put into place through such multilateral processes as Trade-Related Aspects of Intellectual Property Rights (TRIPS). He, along with many advocates globally, has focused on rights-related questions of intellectual property (specifically patents) in regard to the inequities of cost and availability of life-saving pharmaceuticals in the context of the global HIV/AIDS pandemic (Special Rapporteur on the Right to Health, 2004).

2.2 Principles of Rights Applicable to Sexuality (and Some Examples of Their Application in Law)

The formal system of rights is comprised in part as a set of legal obligations of states, and thus a tool for certain kinds of accountability. Here, in this chapter, we are focusing on the formal tools of rights: U.N. standards, national laws and practices, health systems and their policies. Before we turn to the role of law, however, we wish to reaffirm that human rights work comes in many guises, locally and transnationally, such that the strength of human rights work derives not from treaty doctrine but from its resonance with grassroots activism and critiques of power, "the legitimate territory of those who make political demands about basic justice. . . ." (Freedman, 1995a). There is a vast, sometimes contradictory interplay between the creation and claiming of sexual rights through the action of many players, nongovernmental organizations (NGOs), and social movements and their engagement—or dismissal of law and formal rights. Although not addressed in this chapter, we hope our discussion of laws and principles is always read against this reality and not in opposition or ignorance of it.

2.2.1 Law and Principles: How Do They Relate?

As we problematize the legal paradigms around health and sexuality, a first step is noting a key aspect of law itself: Even the concept of law is not "univocal." This is probably easier to figure out in continental jurisprudence, where the notion of law is expressed by two words: *legge* and *diritto* in Italian, *loi* and *droit* in French, *ley* and *derecho* in Spanish, *Gesetz* and *Recht* in German (this distinction originates with Roman law, as expressed by the words *lex* and *jus*). In English, we would distinguish between the words *law* and *right*. Hobbes wrote that "Right, consisteth in liberty to do, or to forbear: whereas Law, determineth, and bindeth to one of them: so that law, and right, differ as much, as obligation, and liberty" (Hobbes, 1950) His words express the idea of law as linked to a positive or statutory standard (associated with *rule*), as opposed to the notion of *right*, which is seen to be an expression of a "larger body of principles."[1]

Laws and rights, rules and principles, play different roles in the understanding of health and sexuality at every level of a legal system, from the sharp divisions at the national level to the more blended

[1]See G. Fletcher, *Three Nearly Sacred Books in Western Law*, in 54 Arkansas Law Review 1 (2001). Fletcher underlines this distinction between statutory law and the "larger body of principles" affirming that "every European language makes this clear linguistic distinction between the code and the law based on the code."

framework of regional (such as the European and Inter-American systems of protection of human rights) or international (United Nations level) systems, in which principles create rights for individuals and duties for states. For health professionals, knowing the principles is thus a different kind of tool than knowing law: Indeed, principles can be used to challenge unjust laws. Knowing principles, such as the meaning and contents of the fundamental right to health allows health professionals set objectives and goals with reference to sexual health in their capacity as health providers. Knowing and understanding the content (and the limits) of the rules by which they operate enables them to use the system, not merely for services, but to work within it for the most effective means to provide sexual health services that conform to both the laws and the rights.

No legal system, national or international, guarantees an autonomous, fundamental right to sexuality. Therefore, the work to develop sexual rights has grown by analogy and incorporation of key principles of the right to the different aspects of sexuality. Sexual rights has particularly drawn power from the notion of *health as a fundamental right* through, at times, the discussion of reproductive health and rights (Chapman, 1995 & Hendriks, 1995) or HIV/AIDS and rights (Miller, 2000; Saiz, 2004). The recognition of principles of *equality*, *nondiscrimination*, and *right to privacy* (especially as formulated in evolving claims around LGBT) also contributed to this growth. For example, the promotion of equal treatment and nondiscrimination as general principles of the law is applied to eliminate discriminatory practices in public health policies as well as the access to health care services for sexual- and gender-nonconforming individuals and communities (Mann et al., 1999). Other key principles include a focus on *the dignity of the person*, the understanding that all *rights are interconnected and interdependent* in their realization, and the participation *of individuals and groups in the determination of issues* affecting them.

Nondiscrimination is a principle that encourages the realization that equality is a core value within rights—"All human beings are born free and equal in dignity and rights" (Universal Declaration of Human Rights, 1948)—yet its application is notoriously unclear. Are like things being compared, so any difference in treatment or result is unfair? Or are the things so unlike that there is no injustice in treating them differently? There are legal systems that address only formal nondiscrimination, which is to say that when the law is neutral on its face it is acceptable, regardless of the real-life barriers to equality. Human rights doctrine moves beyond formal discrimination and addresses both intentional and unintentional discrimination, but this move still leaves human rights doctrine work troubled by comparability as well as the incomprehension of one particular aspect of comparison: What aspects of sexuality can be validly compared?

Regarding discrimination in the treatment of sexual behavior, including the impact of the gender of the sexually active persons, on the one hand, many of the treaty bodies have condemned the discriminatory effect of criminal laws penalizing only same sex behavior (see Toonen, below) or penalizing only women in extramarital sexual activity (Human Rights Committee, 2002). The Committee on the Rights of the

Child has, with some hiccups, evolved a relatively robust approach to nondiscrimination, criticizing different/higher ages of consent for same sex relations (Committee on the Rights of the Child, 2000). On the other hand, as Saiz (2004) notes, "because human rights doctrine allows considerable leeway for subjective interpretation regarding what circumstances may justify unequal treatment . . . the treaty bodies have shown themselves willing to tolerate discrimination in partnership rights in the name of protection of the family." For example, the Human Rights Committee (not quite 10 years after Toonen) determined in Joslin v. New Zealand that "the right to marry" could be applied only to the union between a man and a woman (Human Rights Committee, 1999), but 3 years later, in Young v. Australia, the same committee distinguished that case and held that the denial of veteran pension benefits to the survivor of a same-sex partnership breached equal protection of the law benefits, particularly when unmarried heterosexuals could claim those benefits (Human Rights Committee, 2000).

Nondiscrimination is a potent challenge, as shown by the explosive political resistance to the Brazilian draft resolution in the Commission on Human Rights, expressing "deep concern" over human rights violations on the basis of sexual orientation and noting the Universal Declaration of Human Rights' (UDHR's) statement that all persons were entitled to all human rights without discrimination (Saiz, 2004). This simple statement called all social arrangements into question as discriminatory, thereby engendering massive political opposition. At this time, simple application of the principle of nondiscrimination to social and economic entitlements (Saiz, 2004) does not have the political engine to breach core social institutions, such as marriage, that encompass sexual relationships.

Another key value in human rights work is that of the *limit to limits* on rights: Although rights are almost never absolute, the limitations imposed on their exercise (e.g., rights limited in the interest of public health) must be strictly scrutinized for overbreadth, arbitrariness, and effectiveness. Rather stunningly, in 1994 an authoritative opinion was issued by the Human Rights Committee, the group of U.N. experts that reviews implementation of the International Covenant on Civil and Political Rights. This opinion stated that the "criminalization of homosexual practices cannot be considered a reasonable means or proportionate measure to achieve the aim of preventing the spread of HIV/AIDS" (Human Rights Committee, 1992). They stated that the invasion of privacy and the discriminatory impact of Tasmania's sodomy laws could not be justified by reference to public health needs, especially as evidence indicated that such measures were in fact counterproductive to the spread of HIV/AIDS. The Committee also found that the States' assertion of strong moral beliefs did not overcome respect for the values of privacy and nondiscrimination.

The role of *participation* in human rights has gained increasing attention in the "globalizing" debate over rights: In what way can the content of rights develop to become more truly universal (rather than being declared universal)? Whether by arguing that rights have more cultural resonance and thereby greater likelihood of being effective in

diverse settings globally (An-Na'im, 1995) through greater participation, or arguing that the very content of rights can be effectively addressed only through the involvement of multiple voices, including sexually minoritized persons in the Third World (Narrain, 2001), advocates for human rights increasingly promote participation as a core value. This value aspires to more involvement in making policies and laws, for example, such that the participation of HIV-positive persons in policy and law settings would be facilitated, or persons in sex work would be consulted when laws and policies against the trafficking of prostitution are being written (Saunders, 2004).

When considering meaningful participation, it is notable that the silence about disability in the field of sexual rights on the one hand and about sexuality in disability rights advocacy on the other is ending, with disability rights activists "taking on sexuality" (Shakespeare et al., 1996). Disability intersects with sexuality in ways that shake up easy assumptions about embodiment, roles, and agency (Shakespeare, 2000). Notably, at the time of this writing, a draft Convention on the Rights of Persons with Disabilities is making its way through the United Nations. However, the original, relatively progressive language of the draft (people with disabilities must have "equal opportunity to experience their sexuality, have sexual and other intimate relationships, and experience parenthood") has been revised to proposals qualifying the right to "experience [one's] sexuality" and "have sexual and other intimate relationships" "within a legitimate marriage," "in accordance with the national laws, customs, and traditions in each country" (Long, 2005). Disabled people are participating in this drafting process, but they have not yet been joined by sexual rights advocates. Participation as a value, then, must include the possibility of transformative collective action arising because of interactions across participating groups and not the mere presence of persons of the most affected identity (Shakespeare, 2000).

2.3 Health, Sexuality, and Human Rights in Action: Abuses, Remedies, and the Question of Law

Earlier, when setting out the political context of human rights' engagement with health, we noted that there are four frames for this engagement: the effect of human rights violations on health; the effect of health policies on human rights; the synergistic connections between rights promotion and health promotion; and the claim to the right to health itself. Armed with the notion of key rights principles and the political context of where and how sexual rights language arises, we now look at the practice of applying rights to sexuality in the context of health and then close with reference to law and principles.

2.3.1 Effect of Human Rights Abuses on Health

The effects of human rights abuse on health is a cornerstone of the most traditional work in human rights; yet it faces potentially radical challenges. Traditional human rights work has focused on the abuse of a person by a state agent and has addressed abuses of the body or denials of such civil and political freedoms as the right of expression, freedom from arbitrary detention, and freedom from torture. Many of the

advances in sexual rights appeared first within this framework: egregious violations, such as torture and extrajudicial killing, which cannot be justified on any grounds. This became a good entry place to raise the question of killing because of homosexuality or torture because of one's gender expression or sexual behavior (Miller, 2000; Saiz, 2004). Traditional human rights work against torture fairly quickly began to look at the role of mental and physical health professionals in responding. By the mid-1980s, torture treatment centers were being founded to both treat and advocate against torture and on behalf of services for survivors (Scarry, 1985; Miller, 2004).

Since 2001, a number of the thematic mechanisms (expert/rapporteurs and working groups mandated by the U.N. Commission on Human Rights to study and report on key themes in human rights) have called for information on human rights violations against what they termed "sexual minorities."[2] Their focus was on embodied rights, often violated by violence—sometimes death. They look at arbitrary detention, freedom of expression, violence against women, and religious freedom, among others. The flow of information on sexuality-related aspects of these issues has affected human rights standard settings (e.g., since 1999), and the Special Rapporteur on Extra-Judicial Executions' reports have detailed the execution and killing of persons based on their sexual identity, same-sex sexual conduct, sexual conduct outside marriage (covering both heterosexual and homosexual sex and both capital punishment and family and community level murder tolerated by the state). The Special Rapporteur proposed as a matter of rights principles that capital punishment cannot be legitimately imposed for morals offenses.

Based in information submitted to him, the Special Rapporteur on Torture has focused not only on the extent to which persons are targeted for torture because of their gender identity and sexual identity (which he used to incorporate both orientation and behavior) but also the extent to which this harm extends into the health realm.

> While no relevant statistics are available to the Special Rapporteur, it appears that members of sexual minorities are disproportionately subjected to torture and other forms of ill-treatment, because they fail to conform to socially constructed gender expectations. Indeed, discrimination on grounds of sexual orientation or gender identity may often contribute to the process of the dehumanization of the victim, which is often a necessary condition for torture and ill-treatment to take place. . . . The Special Rapporteur further notes that members of sexual minorities are a particularly vulnerable group with respect to torture in various contexts and that their status may *also affect the consequences of their ill-treatment in terms of their access to complaint procedures or medical treatment in state hospitals, where they may fear further victimization,* [italics added] as well as in terms of legal consequences. . . .
>
> —Special Rapporteur of the Commission on Human Rights, 2001

[2]See "Sexual Minorities: Call for submissions" at http://www.pfc.org.uk/legal/uncall.htm (last checked 5/30/05).

Within this framework, health professionals have a dual concern: to advocate with the tool of rights against the laws and practices that lead to negative health effects (whether because of gender, sexual identity, sexual orientation, sexual behavior, or the use of sexualized violence) and to develop responses adequate to the after-effects of torture, regardless of its political or social predicate. As Lewin and Meyer suggested, however, responsive, respectful, and effective treatment for persons with nonheternormative sexual and gender practices or identities is not yet a norm in health structures globally or enshrined in law, although (as a matter of rights principles) it follows from the pronouncements of many rights and health experts (Lewin & Meyer, 2002).

2.3.2 Human Rights Impact of Health Practices, or Policies

As the above discussion suggests, persons in health structures may violate rights. This concern has historic roots: The International Covenant on Civil and Political Rights' (ICCPR's) article 7 prohibition against torture contains a correlate prohibition: against cruel, inhuman, or degrading treatment, including that "no one shall be subjected without his free consent to medical or scientific experimentation" (International Covenant on Civil and Political Rights, 1966). Although this principle originates in the exposure of the practices of Nazi doctors, it has modern resonance regarding unproven therapies of conversion, forensic practices "proving homosexuality" or loss of virginity (Long, 2004), drug testing, or other practices of scientific research (Meier, 2004). Rothschild pointed out that although many NGO reports increasingly highlight the need for effective health responses and "while the abuse by health care personnel has been intermittently attended to, the overall role of the health system in perpetuating the marginalization of these populations" has not been well theorized or analyzed (Rothschild, 2004), although some health-based policies, such as identity-based quarantine, travel restriction, and mandatory and coercive testing, have been addressed.

2.3.3 Potential Synergistic Effects Between Health and Human Rights

The third approach to health and human rights postulates that "promoting and protecting health requires explicit and concrete efforts to promote and protect human rights and dignity" (Mann et al., 1999). This framework examines how enjoyment of various rights must affirmatively work together in concrete contexts to make any right real. For example, if "the human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence" (Platform for Action of the Fourth World Conference on Women, 1995), a range of rights is needed. They include rights such as nondiscrimination, freedom of information, protection of physical integrity (freedom from torture; liberty and security of the person), the right to enjoy the benefits of scientific progress, the right of individuals and groups to participate in issues affecting them, the right to equal protection of the law.

This approach can take on the many complicated ways that discrimination on the basis of sex, race, sexual orientation, HIV status, marital status, age, and disability, for example, affect health status. It scrutinizies intersecting discriminations, as with sexualized forms of race discrimination, that affect health. Through strategies of documenting interconnected rights claims, advocates have transformed bundles of existing legal obligations into claims for sexual rights across many differently gendered or sexually identified persons. An example is determining if and how single unmarried women, including lesbians, are excluded from reproductive health technologies. At the same time, this approach, especially in regard to public health (protecting persons from discrimination, such as through combating stigma or coercive practices in the HIV/AIDS pandemic leads to better health for individuals and the community), has been an inconsistent incorporation of the fact that many rights are in tension and must be appropriately balanced and evaluated (Oppenheimer et al., 2002).

To revisit *Toonen*, then, one can see that part of the decision rests on this *principle* of interrelationship, leading to a specific critique of a *law*, as the Human Rights Committee noted that criminalizing homosexual activity tends to impede public health programs "by driving underground many of the people at the risk of infection." Criminalization of homosexual activity runs counter to the implementation of effective education programs in respect of the HIV/AIDS prevention (Human Rights Committee, 1992). Thus, rights principles can be used to evaluate the exclusionary or discriminatory effect of specific laws and to allow health policy makers to see which restrictions are justified and which are not in the light of a fuller context of rights, groups, and interventions.

Considering the operation of specific laws as *rules* makes visible the way that criminalization of same-sex sexual conducts may have indirect effects on prevention and treatment of sexually transmitted diseases as well as on measures aimed to protect the sexual health of targeted individuals who undertake the proscribed conducts. Family law and administrative regulations often contain provisions that have negative impacts on de facto couples, such as the way many spousal benefits are couched: the right to visit a partner in a health facility or other state institution or the right to make medical decisions on behalf of the incapable partner. Normative regulations may have significant consequences on equal access to health care for people in same-sex/gender couples. In those cases, the role of the health professional as mediator/rights promoter between the ideal principles, the discrimination through administration, and the patient, is essential.

Keeping in mind the move from the principle of equality to the rules of nondiscrimination (in health law or more generally), one quickly sees that country-level laws are uneven vis-à-vis the question of discrimination and the interconnectedness of rights concerning sexuality. Only Costa Rica (Costa Rica Ley General Sobre el VIH-SIDA,

1998) and South Africa (South Africa Aged Persons Amendment Act, 1998; South Africa Medical Schemes Act, 1998) have national laws prohibiting discrimination on grounds of sexual orientation that have specific applicability to health care. However, several countries in Europe, as well as states (or provinces or territories) and local governments in the United States, Australia, Canada, have enacted antidiscrimination laws that prohibit discrimination on grounds of sexual orientation (rarely, gender expression is included) in the provision of services, which may include healthcare services. Discrimination can be also a *consequence of exclusion* for LGBT people from health practices as set up by specific legal regimes, as noted in the discussions on access to fertilization techniques). As far as same-sex couples are concerned, the possibility of extending either private healthcare insurance or public healthcare benefits to the partner of the same sex has serious consequences at the level of healthcare provision, especially for low-income couples.

2.3.4 Sexual Rights and the Right to Health

The formal system of rights establishes "health" itself as a human right. The International Covenant on Economic, Social and Cultural Rights states in Article 12 that "States Parties . . . recognize the rights of everyone to the highest attainable standard of physical and mental health" (International Covenant on Economic Social and Cultural rights, 1966). The World Health Organization (WHO), pointing out that health is "a state of complete physical, mental and social well-being" that takes into account the individual's biologic and socioeconomic preconditions, rather than the mere absence of disease or infirmity, makes it clear that the notion of right to health as a principle is something very different from the right to be healthy (Chapman, 1998; Gonzalez, 2000; Kinney, 2001). Several other human rights instruments have provisions dealing with the right to health: article 11 of the ICESCR, article 25 of the UDHR, articles 23 and 24 of the Convention of the Rights of the Child (CRC), article 12(2) of CEDAW, article 5 of Committee on the Elimination of Racial Discrimination (CERD), and humanitarian law instruments, as well as article 11 of the European Social Charter, article 33 of the American Declaration of the Rights and Duties of Man, and article 16 of the African Charter of Human and Peoples' Rights. This obligation is to create conditions for health functions as any other rights claim, not as a magic grant of health but as a tool for demands. The content of the specific, useful actions to build health must be developed locally whereas the right to make the claim is global.

The 2004 Report of the Special Rapporteur on the Right to Health, Paul Hunt, squarely rooted key sexual rights in international law and then argued for their specific relevance to the right to health. In this report—which the United States and the Holy See fought to diminish in impact and validity (Williamson, 2004)—the Rapporteur noted that although sexual and reproductive rights may be controversial they are central to fundamental human rights. He also noted the lesser stage of development of sexual rights (in contrast to reproductive rights) and

clarified that some aspects of sexual rights fall within "health" and others outside it (Special Rapporteur on the Right to Health, 2004). He opined that it was established that sexuality is an important characteristic of all human beings and that the full panoply of rights principles and norms (equality, privacy, and the integrity, autonomy, and well-being of the individual) must apply. He wrote that "sexual rights are human rights" and that they "include the right of all persons to express their sexual orientation, with due regard for the well-being and rights of others, without fear of persecution, denial of liberty or social interference" (Special Rapporteur on the Right to Health, 2004). He closed by linking the protection of sexual and reproductive health rights to the struggle against intolerance, gender inequality, HIV/AIDS, and global poverty.

Hunt's report—which does not make new international law but is evidence of what the status of that law is—triggered a hailstorm of attack. He synthesized a wide range of standards and attempted to keep visible the diverse concepts of inequality (age, gender, citizenship, sexual orientation, poverty, reproductive capacity). Hunt linked, but did not subsume, sexual rights to health and sexuality to reproduction. He connected them to established norms and standards of accountability using not only the tripartite framework of respect, protect, and fulfill but also the regime of evaluating health actions in terms of accessibility, *availability*, *acceptability*, and *quality* (Special Rapporteur on the Right to Health, 2004). Health seemed to be the safe site for this highly visible and political step forward for sexual rights, but the attacks by the United States and others also revealed "health" to be vulnerable, in part because of the extent to which health rights also mean affirmative state action and call forth distributive justice questions.

Moving from the international principle to national law, many national constitutions explicitly guarantee a fundamental right to health. National provisions recognizing a right to health provide different definitions, obligations, and contents (Littell, 2002) to respond to the formal set of obligations (respect, protect, fulfill). In common law systems, national courts acknowledge and define its content; in civil law systems, the law expresses the will of the parliament, which ordinary courts must apply and interpret. The impact of this claim can be broad. For instance, although the right to health falls under a section of the Indian Constitution that is more of a policy framework (article 47 of the Directive Principle of State Policy of the Indian Constitution, which establishes the duty of the state to improve public health), the Indian Supreme Court in 1981 made the right to health (as provided by article 12 of ICESCR) directly enforceable as part of the fundamental right to life protected by article 21 of the Constitution. In Francis Coralie Mullin v. The Administrator. Article 70D of the Hungarian Constitution establishes that "[e]veryone living in the territory of the Republic of Hungary has the right to the highest possible level of physical and mental health." The fundamental right to health as protected by article 32 of the Italian Constitution has been interpreted widely in the sense of including psychological and social well-being.

3 Exploring Health, Law, Rights, and Sexuality Interplay Globally and Locally: Three Case Studies

3.1 Specific Challenge for Health Policy Makers and Service Providers

When applying a rights framework to their work, can health care policy makers and practitioners recognize practices of exclusion produced by the desire for "normalization," the impulse to use professional skills resulting in the medicalization of political problems (Kleinman & Kleinman, 1997), or more general exclusions such as geographic inaccessibility or fee structures? Can we see the role of forensic medicine as an accessible tool that should be used respectfully to ensure effective responses to violence in ways that make the law more democratic? For health professionals and policy makers, their practice embodies the application of laws, and their practice reveals the limits of the law in "doing justice."

Because a whole range of material—health and rights—benefits are inherent to the application of these categories, here we explore the possibility that legal categories work as "instruments of regulatory regimes" with invidious effects (Butler, 1993). We consider the direct effects of regulatory regimes as inclusion/exclusion processes, as we believe health professionals must be aware of the possible impact on rights and health deriving from these legal categories. They are factors that determine their work—categories constructed around such ideas as sexual orientation, gender identity, sex, or the reference to LGBT issues in health policies and regulation.

3.2 European Case: The Right to Either A or B as the Basis of Rights and Gender

What follows "materializes" the arguments outlined above on how the language of law administers labels. In other words, the "language of rigid identities" ultimately implies and strengthens the "language of fixed categories" in the realm of law, disempowering the claims of sexually and gender nonnormative persons at their essence.

The shape of rights claims and standards on *gender identity* emerging in Europe provide a paradigmatic example of the vital and contradictory roles that health approaches (here, health regulation) play in the definition of sexual and gender rights. Ironically, what is indeed praiseworthy as progressive rights protection for transsexual people succeeds in part through enforcement of the rigid binary conception of identities as linked to reductive approaches to gender, sexuality, marriage, and reproduction. The cases briefly reviewed below demonstrate how this impact is constituted, as we consider the (regional) case law of the European Court of Human Rights (the Court) as well as the national legislation of some contracting (member) states.

Today, the European Court plays a fundamental role in recognizing the rights of transsexuals in Europe, although it has had a checkered history, first restricting and then often punting cases on technicalities.

The first cases arose during the early 1980s (Van Oosterwijck v. Belgium, 1980; Rees v. United Kingdom, 1986), but claimants made no progress either using claims based on right to private life issues (because of the failures of birth registers to record a male-to-female transition) or asserting their right to marry (abridged by failure to recognize their new sex). Stating that denying transgendered persons their right to marry was not a violation because marriage "refers to the traditional marriage between persons of opposite biological sex" (Rees v. United Kingdom, 1986). These early cases have been seen to betray the real motive behind the rigidly dichotomous legal conception of gender: the "concern to insulate marriage against homosexual incursion" (Rigaux, 1998; Sharpe, 2002). Sharpe (2002) writes that "homophobia of law is a feature of transgender jurisprudence," such that marriage becomes the fulcrum of the heteronormative construction of dichotomous gender, gender roles, and sex between (not within) genders, and therefore must be preserved as is, as an end itself, since it is the institution that preserves that "order of genders."

The Court followed a circuitous route on transgendered rights through the 1990s (Cossey v. United Kingdom, 1990; Sheffield & Horsham v. United Kingdom, 1998), on the one hand accepting in 1992 that there was a violation of privacy rights when French law denied new documents to a male-to-female person because official documentation played such a far-reaching role in daily life within the French civil system (B. v. France, 1992). On the other hand, in 1997 the Court found no violation of privacy rights in the denial of parental rights to nonbiologic, transsexual parents, where the "father" would have been legally a woman (X, Y, and Z v. the United Kingdom, 1997). One can see the clear imprint of the protection of the traditional gender regime even in the disparate results of the two cases. In the first case, the Court seemed more intent on "normalizing" persons within the dichotomous gender paradigm than creating rights to gender identity, as individuals who had "completed" (surgical and hormonal) transition from one gender to the other could undermine the social construction of genders in everyday life through public display as transsexuals. In the later case, the Court was primarily *extending to parental relationships* the biologic gender/sex paradigm.

The most recent and important developments of the European Court of Human Rights are the "twin" 2002 cases of Goodwin v. United Kingdom and I. v. United Kingdom. The applicants, two male-to-female postoperative transsexuals, successfully challenged British law, alleging violation of articles 8 (private life), 12 (right to marry), and 14 (nondiscrimination). The judges argued from a need to resolve the contradiction between supporting irreversible surgery and maintaining a "situation in which postoperative transsexuals live in an intermediate zone as not quite one gender" (Goodwin v. United Kingdom, 2002). The Court asserted that biologic elements do not alone determine a person's sex in life; and by recognizing the violation of the right to marry, they pointed out the need to avoid the paradoxical situation in which a transsexual, legally able to marry, can marry—under heterosexual mar-

riage laws—only a person of the *original* opposite sex (i.e., the same current sex) and not a person of the new opposite sex.

Goodwin is a landmark decision because of its new (nonfixed/biologic) approach to the notion of legal sex and the effects of this approach on marriage, the idea of family, and procreation. In it, the judges also acknowledged rights to dignity, sexual identity, and personal development. *Goodwin* is certainly a step toward recognizing the right to gender expression, but it is limited to individuals who complete the transition from one gender to another. By means of the hormonal–surgical–legal path, these persons "disappear" within the binary sex/gender model: Thus, although *Goodwin* offers legal recognition of a new social status corresponding to a sexual and personal identity (i.e., the condition of the postoperative transsexual person), it cannot address the looming question of gendering (but not one gender) as an aspect of identity if one does not presuppose surgical intervention and absolute transition. Moreover, the underlying ideology that supports the legal recognition of persons who have transitioned from one gender to another remains governed by a heteronormative binary (often also expressed in reproductive norms) and a deep anxiety about disturbing this structure.

National laws reveal most clearly the threads of this underlying ideology. The persistence of filiation and marriage as core social institutions is underscored by the constructive requirement of *sterilization* in many national laws on transexuality. A person desirous of changing sex must render themselves unable to procreate, even as European regional and national law grows to accept same-sex couples and adoption. For example, Sweden's law, the first legal framework on transsexualism enacted in 1972 (Lag om fastställande av konstillhorighet, 1972), simultaneously advances and restricts its subjects, as conditions for certification of the new identity, to two requirements: The person must be unmarried and *unable to procreate*. Surgery is not a requirement but may be authorized (Patti & Will, 1981; Lore & Martini, 1986; Fabeni, 2002).

The most interesting legal framework on transsexualism is found in the German *Transsexuallengesetz* (Gesetz uber die Anderung der Vornamen und die Feststellung der Geschlechtszugehorigkeit in besonderen Fallen-Transsexuellengesetz, 1980). The so-called Transsexual Act, more than any other national law, responds to the individual's desire to express his or her gender identity (Fabeni, 2000). It provides two options, which may be applied either successively or independently of each other.

The first option is the *kleine Lösung* or "minor solution," according to which the judge may authorize a change of name for an applicant who, for 3 years, does not feel that she/he belongs to her/his biologic sex. This solution does not require surgical intervention and can be reversed on the applicant's request. However, the decision of the judge is annulled *if the applicant becomes a parent* after the decision is taken.

In the second option, the so-called major solution in German law, after surgical intervention the judge may authorize gender reassignment and changing the legal sex. The act also requires that the applicant is *not married* and is *not able to procreate*. Although the procedure

for a change of name, or "minor solution," seems to be an optimal way to give full recognition to gender identity. Still, as Sciancalepore and Stanzione (2002) note, the German law remains within the binary system of genders.

The Dutch framework is based on the German one: according to article 29 of the Dutch Civil Code, gender reassignment is possible provided the person cannot procreate, and a change of name is possible separately and at an earlier stage without surgical reassignment (Fabeni, 2000). Thus, national solutions oscillate within a male/female paradigm tightly bound to nontransferable capacities of procreation (for both solutions) and marriage (for the major solution). Moreover, because irreversible surgical intervention—including sterilization—is required to obtain the change of legal sex, full recognition of gender identity is conditioned on "forcible surgery(ies)" (Patti & Will, 1981).

Italian national law and policy reveals another aspect of the construction of dichotomous gender in the conceptual framework on transsexualism: an anxiety about nonconforming bodies (bodies with specific gender identity and conforming sexual characteristics—in Italian *caratteri sessuali*) and the anxiety about having the wrong bodies as parents. Italian law (Italy Legge n. 164, 1982) established that the gender reassignment (change of legal sex and name on civil status records and papers) is disposed of by a decision of the Tribunal aided by experts verifying the psychophysical conditions of the individual. In principle, the gender reassignment would be possible without surgical intervention (Patti & Will, 1981). However, because the law sets out that the change of legal name and sex shall be provided if *sexual characteristics* have been modified, courts have had to interpret what is meant by the words "sexual characteristics": genitals or secondary sexual characters. Italian courts have unanimously chosen the most restrictive interpretation, considering only genitals as sexual characteristics, and therefore *surgery is always a requirement* (Sciancalepore & Stanzione, 2002). Even more tellingly about what truly counts as sexual characteristics most linked to gender identity: In cases of female-to-male transition, *sterilization* is sufficient; in the case of male-to-female transition, modification of primary sexual characteristics (i.e., external male genitals) is required (Sciancalepore & Stanzione, 2002).[3]

Ironically, although in practice the Italian situation appears to be one of the most reductively coercive, a 1985 decision of Constitutional Court no. 161 of 1985 opened the way to another understanding of fundamental *rights to gender identity*. Acknowledging the "contrast between psychological and biologic sex" in transsexual persons, it admitted that the 1982 law, by its terms, accepts a new concept of sexual identity based not only on a person's sexual/physiological attributes but also on psychological and social factors. The Constitutional Court thereby conceived of "sex as a complex feature of an individual's personality, determined by a set of factors; those factors must be balanced

[3]In a few isolated cases, the change of legal sex and name has been authorized even without surgical intervention, generally because of the health conditions of the patient.

in order to find and give priority to the dominant factor" (Decision no. 161, 1985). In this context, it recognized a broad notion of the "right to health" under the Constitution, including not only physical health but also mental well-being and health. Thus, any changes to one's body, if made with a view to ensuring mental well-being, are perfectly legal. Furthermore, the Court stated that the affirmation of one's sexual identity is an inviolable right of the individual, in pursuance of article 2 of the Constitution, because it allows transsexual persons the full development of their personality, both intimately and psychologically, and in their relationships with others.

How do we understand sterilization and surgery as a condition for exercising a right? The right to gender expression becomes the "right to have the opposite gender identity" and thus the right to transition from one gender to another. Sterilization erases a biologic capacity and thus eradicates a social right (reproduction) of the person; surgery acts to build a new appropriately sexed gender. In this, gender identity becomes the resexualization of bodies (Sharpe, 2002). Is this the right to gender identity that is being developed in Europe at a national level and that after *Goodwin* constitutes the minimum core standard for the 44 European countries? Is the right to gender identity in Europe a highly conditioned entitlement trapped in the apparently immutable paradigm of dichotomous male/female genders?

Here the contradictory use of the notion of health is made visible. On the one hand, the content of the right to health evolved to support transition to a new identity, with personal development as the achievement of psychological and "social" health. On the other hand, the regulatory use of health law—health services conditioned on choosing either/or; health experts as gate-keepers, benefits limited to those fitting within social norms—enforces the binary model of genders and reduces the idea of fundamental right to gender identity to a narrow field. Following the *Goodwin* case, the British Parliament approved the Gender Recognition Act 2004, according to which the person who has had gender dysphoria (certified by medical evidence), has lived in the new gender for at least 2 years, and intends to continue to live in the acquired gender for the rest of his or her life may obtain a gender recognition certificate, whose consequence is complete acquisition of the new gender, with the full range of marital and parenting rights (Conway, 2004). It is not clear how in practice the requirements will be interpreted (by doctors? by courts?), but for the first time a law allows transition without requiring surgery or the inability to procreate. This seems to be a real step toward recognition of a right to (trans)gender identity.

The problematic relationship between law and health (and health practices) with regard to gender identity is also evident in the case of persons born "intersex" where "gender attribution is essentially genital attribution" (Kessler & McKenna, 2000). More precisely, gender identity has been attributed according to the presence or absence of a penis. There is no room for "ambiguity." The experiences of intersexed persons in modern medical history reveals that even when biology/"nature" is not dichotomous social norms require that

the person be classified according to dichotomous genders. Health practices and policies are required to contribute to this definition (Karzakis, 2005). The fact that the law requires determining the sex of the infant together with the (social) expectations of the parents has often been the excuse for early interventions on intersex children's genitals. Advocates for intersex persons are increasingly calling such interventions premature. Although often done out of motives of concern and protection, to the advocates, nonetheless, they are a human rights abuse (Human Rights Commission of the City and County of San Francisco, 2005). We are in a highly tentative stage of rights recognition for intersex persons' rights to self-determination, but it is perhaps necessarily still a partial self-determination: One cannot claim the right to be without a clear, exclusive male or female identity and still be human in most modern social contexts (Cabral, 2005).

Health professionals therefore *play a key role* in the legal context for transgender and often intersex persons: They are the ones who "diagnose" gender dysphoria or genital nonconformity; and they then ordain and carry out the psychological, endocrinologic, surgical paths of the transgender or intersex person. Awareness of the complexity of the sociolegal construction would allow them to act in the best interest of the person and might be a strategic tool to stimulate legal reforms that broaden the reach of sexual and gender rights. Health practice in this case mediates between national legislation and the enjoyment of rights. In transgender cases, health professionals would engage with principles deemed as rights in the European Court. With the emerging claims of intersex, new arguments navigate regional and international instruments but with only a few rules.

Health practice in this case is thus also part of the answer to the question: Is the right to health a point of celebration of the fundamental value of identities, or is health the regulatory instrument producing only certain identities? What mix of autonomy, nondiscrimination, the right to form a family, or the right to privacy among others will result in the fairest application of the rules?

3.3 When There Is No Safe Site for Sexual Rights Claiming: At the Intersection of Health, Gender, Sexuality, Age, and Class in Modern India

Examining the kaleidoscopic debates and challenges to a set of laws in the Indian Penal Code that penalize "bad sex" (the rape law and the "unnatural offenses" act, IPC Sec. 375, 376, and 377, respectively) reveals the way that sexuality's regulation by law is often configured in ways that frustrate broader rights claims unless advocates unpack the range of interests and ideologies that operate through the law.

In this case, health-oriented groups, gay identity groups, queer sexualities groups, women's groups, and child rights groups have formed and dissolved alliances and amended tactics in more than a decade's worth of attempts to reform sex and gender crime aspects of the Indian Penal Code. The struggle in India at time of this writing is unresolved. Thus, like all the law/rights/sex debates we present in this chapter, we

only partially capture the many issues in the register of rights, law, and history, especially linkages to colonial and postcolonial politics (Kapur, 2002; Sukthankar, 2002).

Many commentators on the challenge to Sec. 377 ("unnatural offenses" law) draw attention to the complex engagements of local advocates vis-à-vis locally and globally defined meanings implicated in sex law reform, including concerns over law reform in isolation of social movement support (Katyal, 2004; Narrain, 2005). We, however, follow the lead of other commentators who draw on the efforts to reform the rape law and the position of children (Sec. 375/376) to press the point of how laws regulating sex often simultaneously patrol the boundaries of heterosexuality as they create the deviance of "homosexuality" and constrain acceptable gender roles simultaneously (Sukthankar, 2002; Ghosh, 1999). Paying attention to this multidirectional aspect of the law's border-patrolling function is key to understanding the complexity of reforming law regarding sex, as the reform has variously pitted queer, child rights, and women's rights advocates if not against each other then not closely allied.

Criminal law performs its border-drawing function through its paradoxical capacity to protect sexual rights for some (remedying sexual harms, as in protecting persons from coerced sexual activity) while violating sexual rights for others (through penalizing same-sex sexual activity or sex outside marriage). Differently situated groups in every country are in varied positions to command the law's protection versus being subject to its penalties for their sexual action (e.g., women seeking the right to assert the power to say yes or no in marriage, persons seeking the right to say yes to same-sex activity, children/child rights activists seeking rights for those under 18 years of age to have a say in how or when their bodies are used sexually) (Kapur, 2002; Sukthankar, 2002; Miller, 2004). Modern Indian (currently, Hindu–Right-wing driven) politics have successfully converted the sex and gender ideologies still embodied in the Code, drawn up by British Colonial rulers, into norms of gender modesty and appropriate (hetero)sexuality for contemporary Indian society (Narrain, 2004). The modern crime of rape in Section 376 is gender and procreative act-specific: vaginal intercourse forced upon a woman by a man not her husband (Indian Penal Code, 1860). Because of the gender/penetration limits of the law, when child rights advocates seek prosecution of persons suspected of sexual abuse of boys or nonpenile/vaginal abuse of girls/women, they turn to Section 377, which criminalizes "whoever voluntarily has carnal intercourse against the order of nature with any man, woman or animal shall be punished . . . penetration is sufficient to constitute the carnal intercourse necessary" (Indian Penal Code, 1860).

Thus, when advocates (operating variously from health/prevention of HIV/AIDS, gay identity, or nondiscrimination on sexual behavior rubrics) have sought to remove Section 377, they have confronted the argument that it is necessary to "protect boys and women." Although Section 377 has rarely been used to prosecute consensual adult sex between men (Katyal, 2004; Narrain, 2004) its existence has been used to justify various rights-violation practices. For example, the National

Human Rights Commission, in the face of HIV/AIDS groups' petitions, considered its unchallenged existence a reason to uphold the prohibition on condom distribution in Indian prisons (Narrain, 2004), as well as for preventing interventions focusing on men who have sex with men (People's Union for Civil Liberties Karnataka, 2003). Conversely, gay, self-identified sexual and gender minority groups, and health-oriented groups (mostly HIV/AIDS-associated) have agreed that the existence of Section 377 provides the authorizing backdrop against which blackmail, police harassment, and abuse and torture, as well as community and family abuse, is justified (Katyal, 2004; Narrain, 2004).

Advocates during the late 1990s deployed concerns for "health" in legal challenges, specifically calling for judicial reinterpretation of Section 377 in light of evidence of criminality proving to be a barrier to effective outreach efforts aimed at men having sex with men in the context of the increasing rates of HIV/AIDS in India. As Narrain (2004) and Sukthankar (2002) noted, however, this health-oriented effort proved impossible to maintain in light of a vicious police raid of two AIDS outreach and education groups in 2001 in Luknow. The men who have sex with men (MSM) outreach/health-and-harm reduction model had been crafted to fly underneath the radar of law enforcement and avoid the contemporary, politicized, exclusionary struggle over authentic Indian identities (Sukthankar, 2002; Narrain, 2004). After the raid, however, in local authorities' speeches and the media, the outreach and safer-sex materials were depicted as pornographic, and the workers were depicted as purveyors of porn or gay predators. Troublingly, some gay identity groups maintained a prolonged (now broken) silence over the arrests and abuses against the outreach workers, revealing other fault lines in addition to those discussed above. In addition to the gender/sex and age issues raised above, a multiplicity of practices of male–male eroticism arises across urban and rural areas and different regions of India, as poor, working class, and middle class men arrange their sexual and erotic lives differently across heterosexual marriages and community structure; and they are affected in radically different ways by the police powers of surveillance, bribery, and abuse tied to the crimes noted in Section 377 (Katyal, 2004).

Ironically, the raids in Lucknow and the government's response to the legal challenge to Section 377 have, Narrain (2004) notes, had the effect of a public alchemy. They have resulted in the conversion of advocates' initial MSM/health approach into promotion of a gay identity claim. This process has intensified in the glare of global conversations using gay-identity terms and has resulted in being pulled and pushed into national debates by supporters and detractors. Here, the law of Section 377 becomes a tool producing a new gay—and, in contradistinction, a new heterosexual—Indian identity; but these new gay identities are simultaneously produced and condemned by opponents of sexual diversity, a process that has been documented in other nationalizing debates in eastern Europe and southern Africa (Human Rights Watch and the International Gay and Lesbian Human Rights Commission, 1998, 2003).

Thus, health approaches to divergent sexualities have some purchase in gaining rights; but at the same time, in head-on encounters with

criminal law, health as the basis of sexual rights absent additional claims may not have sufficient capacity to resist a dominant ideology intent on excluding and stigmatizing the perverse as unhealthy. A recent, more multivalent campaign in India called Voices Against 377 is striving to keep the sexuality, gender, age, caste, class, and health regulatory issues in view. This movement runs concurrent with the legal challenge to Section 377 (still at times criticized for moving too quickly and arguing with terms that were either "too gay" or not gay enough in the Indian context). While waiting for a judgment, Voices seeks to build coalitions across child rights, women's rights, and gay identified, queer-identified, nonidentified but marginalized communities (Voices against Section 377, 2004). Yet this advocacy still struggles with the triangulation of the law: If Section 377 is struck down (in contrast to being "read down," or reduced, in its reach only to consensual sex in privacy) and other aspects of the Indian Penal Code are left intact, there would be no remedy for rape of boys available in the law. Conversely, because women's groups are divided on the virtues of a gender-neutral rape (and also because a proposed reform failed to reform the marital rape exception), there is no movement on reforming the section of the law that might make it possible to prosecute equally the rape of men and women, boys and girls, regardless of orientation, gender identity, or marital status (Indian Penal Code, 1860; Sukthankar, 2002).

Engagement with the law through a legal petition on "unnatural offenses" has forced a certain politics of sexual rights to the sur face. Rooted in a movement based on rights principles of participation, nondiscrimination, and the conditions for realizing rights, the expanded campaign could become a vehicle to challenge repressive, regulatory ideologies in the broader structures of power and injustice.

3.4 Reflecting on Health as a Site for Claiming Justice

Countries with strong public health care systems would seem to be good models for the more equitable use and distribution of resources. However, our European case study revealed that although such a system may enable social inclusion through access to state-driven interventions and services it may also exclude because of its strong potential for tracking services along social (and sexual) hierarchies. Entitlement to certain rights can be subjected to close patroling, as when access to reproductive health technologies (e.g., fertilization techniques) can be controlled according to dominant ideologies of the good reproductive citizen. For example, Article 5 of the Italian Act on medically assisted insemination (Act No. 40, 2004) perpetuates inequality through providing services conditioned on a heterosexual marital model: Neither individuals nor same-sex couples can undergo the procedures. Lesbians are doubly excluded.

Finally, although global access to resources may not always be visible as an issue for sexuality, resources not only condition the realization of rights but economic development may drive a focus on health, as in the case of developing countries. The tensions in this discussion are evident: Is sexuality accepted as only "one

of the key elements of human capital" and a "means to a productive life" by its service to social development through good health as determined by dominant social norms, as in the India case?

4 Conclusion: Imperilled Rights, New Rights Defenders

4.1 Sex as Geopolitics: How Does the Current Global Struggle over the Meaning of Human Rights and Health Link to Sexuality?

Health has been put at the center of global security, as when the U.N. Security Council convened a special session on HIV/AIDS as a threat to global security or as a precondition as well as a goal of development (UN Secretary General, 2004). *Sexual rights*, in the guise of a highly visible and fought-over draft resolution on nondiscrimination on sexual orientation at the U.N. Commission on Human Rights (Obanda, 2004; Phan, 2004), as well as an aspect of the right to health, has occasioned impassioned speeches by diplomats, roll call votes at the Commission, and letter writing campaigns from the Christian right wing at the international level. Thus, sexuality, health, and human rights have been politicized in new and hypervisible ways globally at the same time that movements to support diverse rights claiming struggle locally with disparate issues, resources, and strategies.

The United States increasingly seeks to turn back the positive international developments in sexual rights and the right to health (Williamson, 2004). Despite the fact that there is a limited right in the United States to engage in consensual, noncommercial sexual behavior outside marriage without penalty and the right to determine if and when sexual activity becomes reproductive, the United States currently advocates internationally with a goal of ensuring that no comparable or greater sexual rights be established elsewhere. In this globalization of the U.S. administration's domestic political/cultural struggle over sexual rights, the United States has joined unusual, issue-specific, powerful North–South alliances. In regard to sexual rights (and a panoply of reproductive rights), the United States works in tandem with the Holy See, a quasi-state player in the United Nations (Butler, 2003; Obanda, 2004; Saiz, 2004) and the Organization of the Islamic Conference (OIC). Although both the Holy See and the OIC are critical of the United States on other issues, each has muted its differences in service of their headline allegiance against expanding sexual rights (Obanda, 2004; Saiz, 2004; Saurbrey, 2004).

Sexual rights, like all human rights, have developed in a complex dynamic between national, regional, and international struggles; between court decisions (law) and diplomatic posturing; between the reasoned enunciation of principles and the manifestos of policies. Understanding sexual rights requires a lens capable of capturing the multivariate intersection of domestic, regional, and international forces and interests (Wilson, 2002; Miller, 2004; Obanda, 2004; Saiz, 2004). Local con-

testations over diverse sexuality and gender challenges often emerge in debates over national identity, sovereignty, and citizenship in nations buffeted by internal and international pressures. As an example, banners in Warsaw at a political rally against European Union accession hosted by the populist Catholic radio show "Radio Maria" in 2003, read (translated): "No to the EU: No Jews, No Masons, and No Sodomites." Displacing attention from economic crises and anxiety over modernization through crusades on behalf of authentic, pure national subjects—and thus against changing generational, gender, or sexual practices (Heng & Devan, 1997; Chanock, 2000)—is a common move.

If one understands the term globalization at its most general sense—"the stretching, deepening, and speeding up of global interconnectedness, i.e., the multiplicity of networks, flows, transactions and relations which transcend states" (McGrew, 1998)—it is clear that globalization operates in ways that challenge many of the traditional claims (however incompletely filled) of the contemporary state system. At the same time, other aspects of globalization offer opportunities for transnational organizing and solidarity. Thus, we arrive at some final paradoxes for rights as a tool for health actors. Human rights both needs a state and threatens forms of that state; health operates transnationally through globalization, and globalization itself threatens the state. Yet health is a fundamental right. We are thus talking about claiming a right that requires attention to the local and the global, even as our work may seem resolutely local (this body, this clinic, this community, this national law on nondiscrimination in health services).

4.2 Health Systems as Sites of Inclusion or Exclusion

Health systems can be seen as sites of citizenship affirmation at its most embodied—for all persons but especially for those of diverse sexuality and gender expression. Yet equality and adequacy of health care for any individual as a point of justice are sustainable only if we understand and support the steps needed for more just and accessible health systems for all (Freedman et al., 2005). If we conceive of health systems as relational, as "a vital part of the social fabric of any society," we see advocacy in health systems as among the tools of citizenship in society (Freedman et al., 2005). This framing reinforces the idea behind using human rights claims as a possible tool for sexually excluded persons in the context of health.

However, it also highlights that removal of the state from its legitimate role in monitoring and responding to the ways in which persons are included in or excluded from quality health care is one of the results of the dominant market-driven approaches to health care. Building accountability—formally through the law and informally through collective action among persons most affected, across differently gendered, racialized, or otherwise marginalized persons and groups—emerges as a key function of rights-based approaches in health. Such action reframes people as "citizens" in the broadest sense because rights-worthy persons are included, and it is also "how to create a

system that encourages, supports, and sustains increasing inclusion, that is redistribution" (Freedman et al., 2005).

4.3 Concluding Thoughts

This chapter has tried to demonstrate the crucial role of health practitioners and policy makers in the conversation focused on rights in the context of sexual health and the health of gender and sexually nonconforming individuals. It seems to us that such a discussion is not possible without "troubling" the notions themselves of the law, sexuality, and health precisely because of their lack of uniform meaning and the complicated forms of interaction among those three "basic" elements.

We have tried to underline in our analysis the different, sometimes contradictory levels on which the legal discourse operates: as a regulatory tool and as a tool of principle. In regard to sexuality principles, both international and national systems have been moving slowly in two essential frameworks for the protection of nonnormative sexualities: within the broad notion of a right to health and as a specific discussion on sexual rights. On the other hand, in the field of law as legislative and regulatory processes, the protection of such rights for nonconforming sexualities is complicated by the "physiologic" limits of the law itself (so long as legal categories do not match with personal identities) and by the "pathologic" restrictive interpretations or applications of the law. The enforcement of legislative provisions by themselves often clash with the idea of rights, a state of well-being, and evolving protection of nonnormative sexuality.

The role of health practitioners and policy makers seems to us of great relevance in both of these domains. The daily practice of health care provision (and the consequent negotiation around rights claims and rights denials) as well as the elaboration of health policies by practitioners and policy makers should make them as the *trait d'union* between the various discourses of the law. This should configure a "triangular" situation in which practitioners and policy makers can make use of the discourse on rights and principles in the most appropriate way to broaden the interpretation of legal rules and the implementation of health practices and policies in the local and national context within the structure of the law itself. This, we argue, better responds to the needs of rights protection of sexual- and gender-nonconforming identities.

In this sense, to better mediate (and ameliorate) the negative impact of administrative regimes in health requires dismantling the rigid conceptions of two mutually constituting binaries: one built around an axis of male-female identity and one built around a heterosexual-homosexual split. For this purpose, Feinberg's depiction (Feinberg, 2001) of contemporary medical professionals refusing treatment to transgender people constitutes the tip of an iceberg of health-undermining and rights undercutting practices and policies derived from ignorance and/or animus toward a population whose gender

defies traditional (and often legal) norms. Other examples of "category errors" linked to simplistic understanding of identity include the failure of health professionals to identify HIV/AIDS in women's bodies during the early stages of the epidemic in the United States (they could only "see" AIDS in male bodies) as well as the failures to address the spread of HIV in men who have sex with men but do not identify themselves as gay (Gilson & Thomas, 2003). Also, health practice operates within regulatory and administrative provisions that work through a system of rigid categorization that may frustrate the principles of justice. In Italy, for instance, a computer-based system of national health care service automatically excludes postoperative (legally) female transsexuals from reimbursable prostate tests, as the tests are considered sex-specific. How can such as system facilitate the well-being of marginalized persons?

This engagement of health practitioners' and policy makers' roles would be particularly valuable for a second reason: Specifically to consider implementing the law in terms of the critical difference between *prevention* and *remedy*. Making use of legal rules and interpreting them in a way that is favorable to sexually different people at the level of health practices and policies may be useful as a *remedial approach*. This approach, though, often limited to individual cases, is self-limiting, as it does not deal with the more general questions of troubling or changing the structural causes of stigmatization, sexual hierarchies, and exclusion. For this reason, health practitioners and policy makers should take seriously a different perspective of legal principles: seeing them as a way to implement a *preventive approach*. Attending to principles then becomes a foundation for avoiding violations of rights rather than "merely" providing remedies. Health practitioners and policy makers should look at principles as a source of ideas for developing preventive tools through the use of structure and power-aware policies and practices built on the bases of sexuality and sexual health. This fits with social history and public health histories of reform, identifying not just evidence but the causes of inequality (Oppenheimer et al., 2002). Of course, the preventive approach must take awareness of its limits, such as relying on multiple steps for implementation, a lack of effective and immediate remedies, and a need to build accountability for reform into the institutional structures.

Therefore, to develop *fair* health systems and policies, practitioners and policy makers should consider both the preventive and remedial approaches and the goals they serve to avoid engaging with the law as a tool of exclusion, as seen in the case studies. Understanding the interrelationships and the potentials arising from contemporary efforts to apply human rights to sexuality in the context of health demands a different concept of the framework of rights, sexuality, and health. More importantly, it requires an explicit understanding of the roles of the various intersectional kinds of power in meaning-making and ordering our societies, as well as around axes of difference in regard to race, citizenship, and nation and the structures

of law and the market. We seek a form of inclusion that can transform the systems so they provide justice for all and are capable of incorporating discriminated-against groups into those systems.

We close, therefore, expressing the need for new coalitions and strategies to achieve health for all. We must modify our understanding of global health structures to move attention to sexual and gender identity as an instrument of value in our larger movement for social justice.

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